Medicare & You 2000

This handbook explains...

- **Your Medicare benefits.**
- **Your Medicare plan choices.**
- **Medicare managed care plans in your area.**
- **Where you can call for help.**

Get the basics on pages 1-3.

Keep this handbook for future reference.

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HEALTH CARE FINANCING ADMINISTRATION

The Federal Medicare Agency

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Sharing *Medicare & You*: Households with up to four people with Medicare will get one handbook to share. This will help save Medicare money. The other people with Medicare in these households will get a postcard. It will tell them how to get an extra handbook if they need it. If your household gets more than one handbook and you want to share copies in the future, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

If you have Employer or Union Health Coverage: See page 10 for important information.

If you are a Railroad Retiree: Call your local Railroad Retirement Board office for answers to Medicare questions. You can find your local office by calling 1-800-808-0772. More information about Medicare for Railroad Retirees is on the Internet at www.rrb.gov.

Medicare & You explains the Medicare program. It is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

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Welcome to *Medicare & You*!

This handbook gives you facts about Medicare. The first three pages are a short summary. You can read it quickly to get the basics. More details are in the rest of this handbook. **Please keep it where you can find it if you need it.**

Use this handbook to find out how Medicare works. It tells you what Medicare covers and what you can do if you have a problem.

This handbook is good (valid) from January 1, 2000 through December 31, 2000. You will get a new handbook every fall to use in the next year. That way, you will always stay up-to-date on Medicare changes.

You should know:

- ✓ Medicare gives you choices in how you get your health care (see page 10).
- ✓ Medicare does not pay for all of your health care costs. You may be able to get more health care coverage (see page 12). You may also be able to get help paying your health care costs (see page 9).
- ✓ Medicare protects you and gives you rights (see page 25).
- ✓ Medicare has a toll-free help line. Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) to get more help with your questions about Medicare (see page 41), or look on the Internet at www.medicare.gov.

We want you to know that we will keep Medicare working for you.

Donna E. Shalala
Secretary, Health and Human Services

Nancy-Ann Min DeParle
Administrator, Health Care Financing Administration

How to Use This Handbook

If you are new to Medicare, or want to learn more about it...

You should read about:	On page(s)...
What Medicare covers	5-8
How to get help paying your health care costs	9
How you can get your Medicare health care coverage	11
Your Medicare rights and protections	25-30
How to sign up for Medicare Part B	31

If you want to learn about Medicare managed care plans...

You should read about:	On page(s)...
Who can join	15
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How to join	18-19
What plans are in your area	Local Information (in the center section)
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If you have health coverage through an employer or union group plan...

You should read about:	On page(s)...
What can happen to your coverage if you join managed care	10
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If you need home health, hospice, mental health, or skilled nursing care...

You should read about:	On page(s)...
What Medicare covers	5-6
Your rights and protections for these types of care	28-29
How to get more detailed information	38

What's New in *Medicare & You* 2000?

A toll-free line for help with your Medicare questions, see page 41.
Medicare managed care plan quality information, see Local Information (center section).
A new home health notice, see page 28.
Comparing nursing homes on the Internet, see page 39.
Prostate cancer screening, see page 7.

Note: Terms in red are defined on pages 42-43.

A Quick Look at Medicare

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some disabled people under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

Medicare has two parts

Part A (Hospital Insurance, see page 4.)

Most people do not have to pay for Part A.

Part B (Medical Insurance, see page 4.)

Most people pay monthly for Part B.

You may have choices in how you get your health care.

- **The Original Medicare Plan** - This plan is available everywhere in the United States (see page 11). It is the way most people get their Medicare Part A and Part B health care. You may go to any doctor, specialist, or hospital that accepts Medicare. You pay your share, and Medicare pays its share. Some things are not covered, like prescription drugs.
- **Medicare Managed Care Plans** - These are health care choices in some areas of the country (see page 15). In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare covers some tests and shots that can help you stay healthy (see page 7).

You can get help with your Medicare questions (see page 41).

What are Part A and Part B?

PART A (HOSPITAL INSURANCE)

Helps Pay For: Care in hospitals, skilled nursing facilities, hospice, and some home health care. (See page 5.)

Cost: Most people do not have to pay a monthly payment (premium) for Part A because they (or a spouse) paid Medicare taxes while they were working.

For More Information:

Call your Fiscal Intermediary about bills and services (see page 23). Your Fiscal Intermediary handles your Medicare Part A bills.

If you (or your spouse) did not pay Medicare taxes while you worked, you may be able to get Part A. If you are not sure if you have Part A, look on your red, white, and blue Medicare card. It will show "Part A (Hospital Insurance)" on the lower left corner of the card (see page 11). You can also call your local Social Security office, or call Social Security at 1-800-772-1213.

PART B (MEDICAL INSURANCE)

Helps Pay For: Doctors, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health services. Part B helps pay for covered doctor services that are medically necessary. (See pages 6-8.)

For More Information:

Call your Medicare Carrier about bills and services (see page 23). Your Medicare Carrier handles your Medicare Part B bills.

Cost: You pay the Medicare Part B premium of $45.50* per month. This is the 1999 amount and may change January 1, 2000. In some cases, this amount may be higher if you did not choose Part B when you first became eligible. **The cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not take it.** See page 31 for more Part B enrollment information.

Enrolling in Part B is your choice. If you choose to have Part B, the premium is usually taken out of your monthly Social Security, Railroad Retirement, or Civil Service Retirement payment. If you do not get any of the above payments, Medicare sends you a bill for your Part B premium every 3 months. You should get your Medicare premium bill by the 10th of the month. If you have not received your bill by the 10th, call Social Security at 1-800-772-1213.

* New Part B premium amount will be available by January 1, 2000.

Medicare Part A (Hospital Insurance) Covers:	What You Pay in 1999* in the Original Medicare Plan
Hospital Stays: Semiprivate room, meals, general nursing and other hospital services and supplies. This does not include private duty nursing, a television or telephone in your room, or a private room, unless medically necessary. Inpatient mental health care coverage in a psychiatric facility is limited to 190 days in a lifetime.	**For each benefit period you pay:** • A total of $768 for a hospital stay of 1-60 days. • $192 per day for days 61-90 of a hospital stay. • $384 per day for days 91-150 of a hospital stay. (See Reserve Days on page 43.) • All costs for each day beyond 150 days.
Skilled Nursing Facility (SNF) Care:** Semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a 3-day hospital stay). For more information on SNFs and long-term care (see pages 28 and 38).	**For each benefit period you pay:** • Nothing for the first 20 days. • Up to $96 per day for days 21-100. • All costs beyond the 100th day in the benefit period. If you have questions about SNF care and conditions of coverage, call your Fiscal Intermediary. This is the company that pays Medicare Part A bills (see page 23).
Home Health Care:** Part-time skilled nursing care, physical therapy, speech-language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services (see pages 28 and 38).	**You pay:** • Nothing for home health care services. • 20% of approved amount for durable medical equipment. If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary (see page 24).
Hospice Care:** Medical and support services from a Medicare-approved hospice, drugs for symptom control and pain relief, short-term respite care, care in a hospice facility, hospital, or nursing home when necessary, and other services not otherwise covered by Medicare. Home care is also covered.	**You pay:** • A copayment of up to $5 for outpatient prescription drugs and a $5 per day copayment for inpatient respite care (short-term care given to a hospice patient by another care giver, so that the usual care giver can rest). The copayment can change depending on where you live. If you have questions about hospice care and conditions of coverage, call your Regional Home Health Intermediary (see page 24).
Blood: Given at a hospital or skilled nursing facility during a covered stay.	**You pay:** • For the first 3 pints of blood.

* New Part A and B amounts will be available by January 1, 2000.

** You must meet certain conditions in order for Medicare to cover these services.

If you have general questions about Medicare Part A, call your Fiscal Intermediary. This is the company that pays Medicare Part A bills (see page 23).

Medicare Part B (Medical Insurance) Covers:	What You Pay in 1999* in the Original Medicare Plan
Medical and Other Services: Doctors' services (except for routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers outpatient physical and occupational therapy including speech-language therapy, and mental health services.	**You pay:** • $100 deductible (pay once per calendar year). • 20% of approved amount after the deductible, except in the outpatient setting. (See question 12 on page 35.) • 20% of $1,500 for all outpatient physical and speech therapy services and 20% of $1,500 for all outpatient occupational therapy services. You pay all charges above $1,500. **(Hospital outpatient therapy services do not count towards the $1,500 limits.)** • 50% for most outpatient mental health.
Clinical Laboratory Service: Blood tests, urinalysis, and more.	**You pay:** • Nothing for services.
Home Health Care:** Part-time skilled care, home health aide services, durable medical equipment when supplied by a home health agency while getting Medicare covered home health care, and other supplies and services.	**You pay:** • Nothing for services. • 20% of approved amount for durable medical equipment.
Outpatient Hospital Services: Services for the diagnosis or treatment of an illness or injury.	**You pay:** • 20% of the charged amount (after the deductible). During the year 2000, this will change to a set copayment amount.
Blood: Pints of blood needed as an outpatient, or as part of a Part B covered service.	**You pay:** • For the first 3 pints of blood, then 20% of the approved amount for additional pints of blood (after the deductible).

* New Part A & B amounts will be available by January 1, 2000.

** You must meet certain conditions in order for Medicare to cover these services.

Note: Actual amounts you must pay are higher if the doctor does not accept assignment (see page 35). If you have general questions about your Medicare Part B coverage, call your Medicare Carrier. This is the company that pays Medicare Part B bills (see page 23).

Medicare Part B Covered Preventive Services	Who is covered...	What you pay...
Bone Mass Measurements: Varies with your health status.	Certain people with Medicare who are at risk for losing bone mass.	20% of the Medicare approved amount after the yearly Part B deductible.
Colorectal Cancer Screening: • Fecal Occult Blood Test - Once every year. • Flexible Sigmoidoscopy - Once every four years. • Colonoscopy - Once every two years if you are high risk for cancer of the colon. • Barium Enema - Doctor can substitute for sigmoidoscopy or colonoscopy.	All people with Medicare age 50 and older. However, there is no age limit for having a colonoscopy.	No coinsurance and no Part B deductible for the fecal occult blood test. For all other tests, 20% of the Medicare approved amount after the yearly Part B deductible.
Diabetes Monitoring: Includes coverage for glucose monitors, test strips, lancets, and self-management training.	All people with Medicare who have diabetes (insulin users and non-users).	20% of the Medicare approved amount after the yearly Part B deductible.
Mammogram Screening: Once every year.	All women with Medicare age 40 and older.	20% of the Medicare approved amount with no Part B deductible.
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every three years. Once every year if you are high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap smear in the preceding three years.	All women with Medicare.	No coinsurance and no Part B deductible for the Pap smear (clinical laboratory charge). For doctor services and all other exams, 20% of the Medicare approved amount with no Part B deductible.
Prostate Cancer Screening: Starting January 1, 2000 • Digital Rectal Examination - Once every year. • Prostate Specific Antigen (PSA) Test - Once every year.	All men with Medicare age 50 and older.	Generally, 20% of the Medicare approved amount after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA Test.
Vaccinations: • Flu Shot - Once every year. • Pneumonia Shot - One may be all you ever need, ask your doctor. • Hepatitis B Shot - If you are at medium to high risk for hepatitis.	All people with Medicare.	No coinsurance and no Part B deductible for flu and pneumonia shots if the doctor accepts assignment (see page 35). For Hepatitis B shots, 20% of the Medicare approved amount after the Part B deductible.

Part B also helps pay for:

- Ambulance services (limited coverage).
- Artificial limbs and eyes.
- Braces - arm, leg, back, and neck.
- Chiropractic services (limited).
- Emergency care.
- Eyeglasses - one pair after cataract surgery with an intraocular lens.
- Kidney dialysis and kidney transplants.
- Medical supplies - items such as ostomy bags, surgical dressings, splints, casts, and some diabetic supplies.
- Outpatient prescription drugs (very limited).
- Preventive services (see page 7).
- Prosthetic devices, including breast prothesis after mastectomy.
- Services of practitioners such as clinical psychologists, and social workers, and nurse practitioners.
- Transplants - heart, lung, and liver (under certain conditions).
- X-rays and some other diagnostic tests.

What is not paid for by Medicare Part A and Part B in the Original Medicare Plan?

The Original Medicare Plan does not cover everything. Your out-of-pocket costs for health care will include but are not limited to:

- Your monthly Part B premium ($45.50 in 1999*).
- Deductibles, coinsurance or copayments when you get health care services (see the "What You Pay" part of the charts on pages 5-7).
- Outpatient prescription drugs (with only a few exceptions).
- Routine or yearly physical exams.
- Vaccinations except as listed on page 7.
- Orthopedic shoes.
- Custodial care (help with bathing, dressing, toileting, and eating) at home or in a nursing home.
- Most dental care and dentures.
- Routine foot care.
- Hearing aids.
- Routine eye care.
- Health care you get while traveling outside of the United States (except under limited circumstances).
- Cosmetic surgery.

Outpatient physical and occupational therapy services, including speech-language therapy except for those you get in hospital outpatient departments, have limits for each calendar year. The Original Medicare Plan does pay for some preventive care, but not all of it (see page 7).

You may be able to get help to cover the costs Medicare does not cover (see page 12). You may be able to join a Medicare managed care plan and get extra benefits (see pages 15-20).

* New Part A and B amounts will be available by January 1, 2000.

How can I get help to pay health care costs?

If you cannot afford to pay your Medicare premiums and other costs, you may be able to get help from your State. You may qualify for a Medicare assistance program as a Qualified Medicare Beneficiary (QMB), Specified Low-Income Beneficiary (SLMB), or Qualifying Individual (QI).

These programs are for certain people who are entitled to Medicare and have a low income. They may pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance. To qualify, you must have Part A (Hospital Insurance), a limited income (see below), and your assets, such as bank accounts, stocks, and bonds must not be more than $4,000 for a single person, or $6,000 for a couple.

If you are not sure if you have Part A, look on your red, white, and blue Medicare card. It will show "Part A (Hospital Insurance)" on the lower left corner of the card, or call Social Security toll-free at 1-800-772-1213.

	1999 Monthly Income Limit*		
	Individual	Couple	Program Pays Medicare's
QMB	$707	$942	Premiums, deductibles, and coinsurance
SLMB	$844	$1,126	Monthly Part B premium
QI-1	$947	$1,265	Monthly Part B premium
QI-2	$1,222	$1,633	A small part of the monthly Part B premium

New Health Insurance For Children under Age 19

A new Children's Health Insurance Program is available in your State. Call 1-877-KIDS-NOW (1-877-543-7669) for more details.

For more information about these programs, call the medical assistance office in your area (see page 24). If you need further assistance, please call 1-800-MEDICARE (1-800-633-4227). Someone there will help you find the telephone number in your State.

*Slightly higher amounts are allowed in Alaska and Hawaii. Income limits will change slightly in 2000, and new limits will be available by April 1, 2000.

How You Get Your Health Care is Important

Do you know what health care coverage you have? If not, you should find out. Medicare may not be the only source of health care coverage you can get. You might be able to get health care coverage or assistance that may lower your out-of-pocket costs or give you more benefits than Medicare does.

If you or your spouse still work or are retired, you may be able to get employer or union health care coverage:

- Call the employer or union to find out if you can get health care coverage based on your or your spouse's past or present employment.
- If you can get this coverage, ask your benefit administrator to help you compare their costs and benefits to Medicare's.

Caution: If you already have employer or union coverage, talk to your employer or union before you sign up for a Medicare health plan. You may not be able to get your coverage back.

If you are a veteran or a military retiree, you may be entitled to medical benefits:

- If you are a veteran, call the U.S. Department of Veteran Affairs at 1-800-827-1000. If you are retired from the military, you may also call the Department of Defense at 1-800-321-1080 for more information.

If you have a low income and limited assets, you may qualify for help paying your health care costs:

- See page 9 to see if you qualify for help in paying your health care costs. You may also call the medical assistance office in your State (see page 24).

Whether you qualify for employer or union, military, or Medicare health care coverage, you should learn about all of the different ways you may be able to get your health care. What you choose will affect how much you pay, what benefits you may have, which doctors you can see, and other things that may be important to you (see page 11).

What are my Medicare plan choices?

Congress created the Medicare + Choice program to let more private insurance companies offer coverage to people in Medicare. The next two sections will talk about the two most common ways you may be able to get your health care in Medicare:

1. **The Original Medicare Plan** (available nationwide)

2. **Medicare Managed Care Plans**

   If you live in an area served by Medicare managed care plans, you may have other choices in how you get your Medicare health care. Read pages 15-20 to see if you qualify.

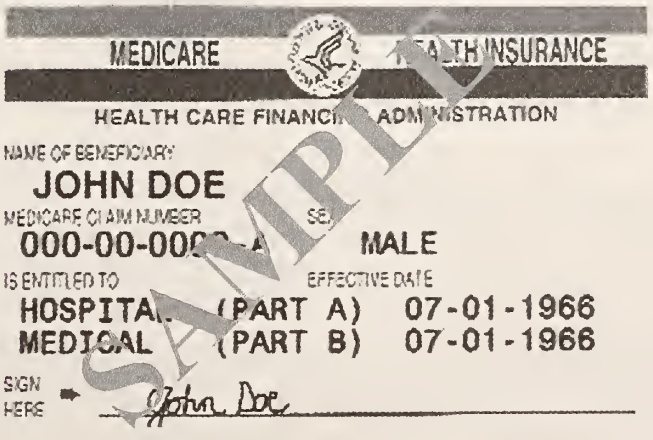
No matter how you get your Medicare health care, you are still in the Medicare program.

1. The Original Medicare Plan

The Original Medicare Plan is also known as "fee-for-service." You are usually charged a fee for each health care service or supply you get. **If you are happy getting your health care this way, you do not have to change.** You will stay in the Original Medicare Plan unless you join a Medicare managed care plan.

You can tell you are in the Original Medicare Plan if:

- You use your red, white, and blue Medicare card when you get health care (see below).



In the Original Medicare Plan:

- You may go to any doctor, specialist, or hospital that accepts Medicare. Generally, a fee is charged each time you get a service.
- You pay the monthly Part B premium of $45.50 (in 1999), which is usually taken out of your monthly Social Security, Railroad Retirement, or Civil Service Retirement payment. You also pay an amount for your health care each year (deductibles) before Medicare pays its part. Then, Medicare pays its share, and you pay your share (coinsurance). After you get a health care service, you get an Explanation of Medicare Benefits or a Medicare Summary Notice in the mail. These are sent by a company that handles bills for Medicare. The notice lists what was charged, what Medicare paid, and how much you must pay.

How do my out-of-pocket costs vary?

Your costs depend on:

- Whether your doctor or supplier agrees to accept what Medicare pays (see question 12 on page 35).
- How often you need health care.
- What type of health care you need.
- Whether you get health care while traveling outside of the United States.
- Whether you choose to pay for services or supplies not covered by Medicare (see "You are protected from unexpected bills" on page 27).

To help cover the costs Medicare does not cover:

- Keep or get employer or union health coverage (see page 10), or
- Buy a Medicare Supplemental Insurance (Medigap) policy (see page 13), or
- Check if you qualify for help from your State (see page 9).

For more information on the Original Medicare Plan, see questions 10-12 on pages 34-35.

What types of private insurance supplement Medicare?

There are many types of private health coverage that pay for some or all of the health care costs not covered by Medicare. All of these types are sometimes called "supplemental coverage." These include:

- Employee Coverage* (from an employer or union);
- Retiree Coverage* (from a former employer or union); and
- Medigap Insurance (from a private company or group).

What is Medigap?

A "Medigap" policy fills gaps in Original Medicare Plan coverage. Medigap insurance must follow Federal and State laws. These laws protect you. All Medigap policies are clearly marked "Medicare Supplemental Insurance." For the rest of this book, Medicare Supplemental Insurance policies will be called Medigap.

In most states, a Medigap policy must be one of ten standardized policies to help you compare them easily. Each policy has a different set of benefits. Two of the standardized policies may have a high deductible option. In addition, any standardized policy may be sold as a "Medicare SELECT" policy. Medicare SELECT policies usually cost less because you must use certain hospitals and doctors. In an emergency, you may use any doctor or hospital.

If you are in a Medicare managed care plan, or if you are covered by Medicaid, you do not need a Medigap policy. Generally, it is not legal for anyone to sell you one in these cases.

When do most people first buy a Medigap policy?

For six months after the first day of the month in which you are age 65 or older and first join Medicare Part B, you have the right to buy the Medigap policy of your choice. During this open enrollment period, the insurance company cannot deny you insurance coverage or change the price of a policy because of past or current health problems. Once you enroll in Part B, the six month Medigap open enrollment period starts and cannot be changed.

*If you drop your employer or union based group health coverage, you probably won't be able to get it back. Call your employer's or union's benefit administrator for more information.

Important ▸

Except as described below, if you do not buy a Medigap policy during your open enrollment period you may not be able to buy the one you want, or you may be charged more for the policy. If you drop your Medigap policy, you may not be able to get it back. There are certain situations however, where you may have the right to get a Medigap policy after your open enrollment period. In these cases, the insurance company can not deny you coverage, or change the price of a policy because of past or present health problems. For example:

- You lose your health coverage (through no fault of your own) under a Medicare managed care plan, Medigap or Medicare SELECT policy, or employer coverage, or
- You join a Medicare managed care plan for the first time and within one year of joining, you decide you want to leave managed care. If you were new to Medicare when you joined the plan, you may be able to choose any Medigap policy you want. If you already had a Medigap policy before you joined the plan, you may be able to get the same policy back.

To find out if these rights apply to your situation, call 1-800-MEDICARE (1-800-633-4227). You can talk to a customer service representative and order a pamphlet called *Medicare Supplemental Insurance (Medigap) Policies and Protections*. To get these protections, you must apply for a Medigap policy within **63 calendar days** after your coverage ends.

For More Information about Medigap Policies ▸

- Call 1-800-MEDICARE (1-800-633-4227) and ask for a copy of the *Guide to Health Insurance for People with Medicare*. This guide gives information on buying a Medigap policy, using Medigap insurance and other kinds of health insurance, and your rights and protections. The guide is also available on the Internet at www.medicare.gov.
- Contact your State Health Insurance Assistance Program (see page 24). Volunteer counselors can help you understand and compare your Medigap choices. This service is free.

2. Medicare Managed Care Plans

Medicare managed care plans are offered by private companies. They are a different way to get your Medicare health care. Many people with Medicare have managed care as an option. A company can decide that a plan will be available to everyone with Medicare in a State, or be open only in certain counties. The company may also choose to offer more than one plan in an area, with different benefits and costs. **Each year, managed care companies can decide to join or leave Medicare.**

Some people in Medicare have already joined a managed care plan. If you are in a Medicare managed care plan, you should have a membership card with the name of the plan on it. If you are not sure if you are in a Medicare managed care plan, you can call the number listed on your membership card, or call your local Social Security office, or call Social Security at 1-800-772-1213.

If you join a Medicare managed care plan:

- You are still in the Medicare program.
- You must continue to pay the monthly Part B premium of $45.50 (in 1999).
- You will keep your Medicare rights and protections (see pages 25-30).
- You still get all your regular Medicare covered services (see pages 5-8).

Can I join a Medicare managed care plan?

You can join a Medicare managed care plan if:

- You have both Part A (Hospital Insurance) and Part B (Medical Insurance).
- You do not have End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant). However, if you have End-Stage Renal Disease and are already in a Medicare managed care plan, you can stay in your plan. Call 1-800-MEDICARE (1-800-633-4227) for more information about End-Stage Renal Disease and Medicare managed care plans.
- You live in the service area of the plan. The service area is where the plan accepts members and where you get services from the plan. In general, if you move out of the plan's service area you cannot stay in the plan. You must disenroll and you will then be covered under the Original Medicare Plan. Or, you can choose to join another Medicare managed care plan, if one is available in your new area.

How does managed care work?

- In most managed care plans, you can only go to certain doctors and hospitals who have agreed to treat members of the plan. Generally, you can only see a specialist (like a cardiologist) when you get a referral (see page 37), which means your plan doctor says it is OK to go.
- You can often get extra benefits, like outpatient prescription drugs.
- Some managed care plans offer a Point-of-Service option. This allows you to go to other doctors and hospitals who are not on the plan's list. Most of the time this option costs you more, and gives you more choices.

How do my out-of-pocket costs vary?

Your costs depend on:

- Whether the plan charges a premium in addition to the monthly Part B premium ($45.50 in 1999).
- How much the plan charges per visit, such as a $5 or $10 copayment every time you see your doctor (in place of the 20% coinsurance charged in Original Medicare).
- The type of health care you need and how often you get it.
- How much the plan charges for extra benefits.
- Whether you get health care outside the service area of the plan (except in an emergency, see page 37).

What do I need to think about when I compare managed care plans?

- **Cost:** What will my out-of-pocket costs be?
- **Doctor Choice:** Which doctors are in the plan? Can I see the doctor(s) I want to see?
- **Benefits:** Will I get extra services and items, like outpatient prescription drugs?
- **Convenience:** Where are the offices of the plan's doctors and what are their hours? (Generally, you cannot get health care outside of a plan's service area.)
- **Quality:** How well does the plan keep its members healthy or treat them when they are sick? You can learn more about quality in the Local Information section in the center of this book.

TO CHOOSE A MEDICARE MANAGED CARE PLAN, YOU NEED TO KNOW...	TO FIND OUT...
Is the plan offered where I live, what does it cost, and what extra benefits are covered?	Call 1-800-MEDICARE (1-800-633-4227) and ask for a free, up-to-date list of all the plans offered where you live, with detailed information about extra benefits and costs. OR Call any plan you may be interested in from the list on Local Information pages 1-2 (in the center section). They can tell you if the plan is offered where you live and can send you up-to-date, detailed information about their extra benefits and costs. OR Look at Medicare Compare on the Internet at www.medicare.gov. If you do not have a personal computer, your local library or senior center may be able to help you.
What doctors or hospitals belong to that plan?	Call your doctor to ask if he or she is in the plan and would continue to see you if you joined the plan.
How does the plan rate in quality?	Look on the Local Information pages (in the center section), or call 1-800-MEDICARE (1-800-633-4227) and ask for quality and satisfaction information. It will be mailed free of charge. OR Look at Medicare Compare on the Internet on www.medicare.gov. If you do not have a personal computer, your local library or senior center may be able to help you.
How does the plan respond to grievances?	Call the plan. Beginning on February 1, 2000, you can ask any managed care plan for information about any grievances and appeals that were made (see page 26).
Who can help me compare plans?	Call your State Health Insurance Assistance Program (see page 24). Volunteer counselors can help you compare the managed care plans available to you.

How do I get information to help me decide whether to join a managed care plan?

On pages LI: 1-2 of the Local Information section in the center of this book, you will see a list of Medicare managed care plans with some basic information. You will need to get up-to-date information about each plan you are interested in before you make any decision about joining one of them (see page 20). Plans can join or leave Medicare, and costs and extra benefits can change.

Before you join a Medicare managed care plan, keep in mind that...

- Managed care plans are offered by private companies. Each year they can change the extra benefits they offer and how much they charge. The plans must tell you about these changes in advance.
- When managed care plans sign a contract with Medicare, they agree to stay for at least one calendar year. Each year, they make a business decision to stay or leave the Medicare program.
- Doctors can join or leave managed care plans at any time.
- Managed care plans may charge an extra monthly premium, in addition to your monthly Part B premium.
- Some managed care companies limit the number of members in their plans. These plans may not accept new members all of the time. A company can tell you if a plan has reached its limit, or if it is still signing up new members.

How do I join a managed care plan?

To join a plan:

1. Call the plan and request an enrollment form.
2. Fill out the form and mail it to the plan.
3. You will get a letter telling you when your coverage begins.

Note: During the month of November, Medicare managed care plans (with some exceptions) must accept new members. If you join in November, your coverage begins on January 1, 2000.

You can't join more than one managed care plan at the same time. If you try to join more than one managed care plan with the same effective dates, you will end up in the same health plan that you started out with (either a managed care plan or the Original Medicare Plan), and you will keep getting your health care through that plan.

If you join a managed care plan and change your mind, you must call the plan you joined before the date your coverage begins. Tell them you want to cancel. Depending on when you call, the plan may ask you to fill out a form to leave. If the plan does not ask you to, you do not have to fill out or send any form to leave this plan. After you cancel, you can stay with your current plan (including Original Medicare Plan) or join a new managed care plan.

How do I leave a managed care plan?

In the year 2000, you may leave a plan at any time for any reason. Write to the plan or the Social Security Administration and tell them you want to leave. When you leave a plan you are automatically returned to the Original Medicare Plan (unless you join another Medicare managed care plan). In most cases, your new coverage starts the month after you leave the plan.

Starting in 2002, you may only be able to leave a plan at certain times. Call 1-800-MEDICARE (1-800-633-4227) for more information.

Can I keep my Medigap policy if I join a managed care plan?

If you join a Medicare managed care plan, you may keep your Medigap policy (but you can't use it unless you return to the Original Medicare Plan). If you drop your Medigap policy, you may have the right to get another Medigap policy later if:

- You lose your Medicare managed care plan coverage (through no fault of your own), or
- You join a Medicare managed care plan for the first time, and within one year of joining, you decide you want to leave managed care. If you were new to Medicare when you joined the plan, you may be able to choose any Medigap policy you want. If you already had a Medigap policy before you joined the plan, you may be able to get the same policy back.

For more information about Medigap policies, see pages 13-14.

To find out if these rights apply to your situation, call 1-800-MEDICARE (1-800-633-4227). You can talk to a customer service representative and order a pamphlet called *Medicare Supplemental Insurance (Medigap) Policies and Protections*. To get these protections, you must apply for a Medigap policy **within 63 calendar days** after your coverage ends.

For More Information About How You Get Your Health Care ▸

1. See questions 13-18 on pages 36-37.
2. Call **1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048** for the hearing and speech impaired) and ask for:
   - Detailed plan information - a list of benefits and costs of the plans available where you live.
   - Quality information for the plans available where you live.
   - The *Worksheet for Comparing Medicare Health Plans* (to help you compare plans).
   - The *Guide to Health Insurance for People with Medicare*. This guide gives information on buying a Medigap Policy, using Medigap insurance and other kinds of health insurance, and your rights and protections. The guide is also available on the Internet at www.medicare.gov.

For More Information About Other Plans ▸

You may have heard about Medicare Medical Savings Accounts and Private Fee-for-Service plans. At the time this handbook was printed, no private insurance companies were offering these types of plans to people with Medicare. To find out if any of these plans have become available in your area or to get pamphlets about these plans, call **1-800-MEDICARE (1-800-633-4227)**, and ask for:

- *Your Guide to Medicare Medical Savings Accounts.*
- *Your Guide to Private Fee-for-Service Plans.*

Year 2000 Medicare Health Plans For Delaware, Maryland, Virginia, Washington D.C., and West Virginia

Plan Name - Location	Telephone Number	Monthly Premium*	Is Prescription Drug Coverage Available?
Delaware			
CIGNA HealthCare of Delaware, Inc. New Castle Area	1(800)547-5843	$30	Yes, in all counties
Principal Health Care of Delaware, Inc. Delaware	1(877)227-3521	$81	No
TRICARE Senior Prime (Military Retirees) TRICARE Northeast	1(888)999-5391	$0	Yes, in all counties
Maryland			
CIGNA HealthCare Mid-Atlantic, Inc. MD, VA and Washington D.C. Areas	1(800)547-5843	$0-$70	Yes, in all counties
FreeState Health Plan, Inc. Maryland and D.C. (Pending Federal Approval)	1(410)308-8327	$50	Yes, in all counties
Kaiser Fndn Hp of the Mid-Atlantic Sts (Information Not Available)	Not Available	Not Available	Not Available
TRICARE Senior Prime (Military Retirees) TRICARE Northeast	1(888)999-5391	$0	Yes, in all counties
United HealthCare Insurance Company Greater Baltimore/Southern Maryland (Pending Federal Approval)	1(800)393-0993	$0	No
United Healthcare of the MidAtlantic, Inc. Maryland (Nine Counties)	1(800)414-0562	$0	Yes, in all counties

Call 1-800-MEDICARE (1-800-633-4227) for more detailed information about health plans.

* You must continue to pay the monthly Part B premium ($45.50 in 1999). Some companies offer more than one plan at different premium amounts. n those cases, we list the lowest and highest premiums for the plans offered. Some plans may also offer extra benefits for an additional cost.

Year 2000 Medicare Health Plans For Delaware, Maryland, Virginia, Washington D.C., and West Virginia

Plan Name - Location	Telephone Number	Monthly Premium*	Is Prescription Drug Coverage Available?
Virginia			
CIGNA HealthCare Mid-Atlantic, Inc. MD, VA and Washington D.C. Areas	1(800)547-5843	$0	Yes, in all counties
CIGNA HealthCare of Virginia, Inc. Central Virginia	1(800)547-5843	$25-$49	Yes, in all counties
John Deere Health Plan, Inc. East Tennessee and South Western Virginia (Pending Federal Approval)	1(800)209-0034	$20-$45	Yes, in all counties
Washington D.C.			
CIGNA HealthCare Mid-Atlantic, Inc. MD, VA and Washington D.C. Areas	1(800)547-5843	$0	Yes, in all counties
FreeState Health Plan, Inc. Maryland and D.C. (Pending Federal Approval)	1(410)308-8327	$50	Yes, in all counties
West Virginia			
HealthAssurance HMO Northwestern West Virginia	1(800)470-4272	$0	No
The Health Plan Northern West Virginia & Southeastern Ohio	1(740)695-7907	$97.29-$97.31	No
The Health Plan The Health Plan (Pending Federal Approval)	1(740)695-7907	$39-$49	No

Call 1-800-MEDICARE (1-800-633-4227) for more detailed information about health plans.

* You must continue to pay the monthly Part B premium ($45.50 in 1999). Some companies offer more than one plan at different premium amounts. In those cases, we list the lowest and highest premiums for the plans offered. Some plans may also offer extra benefits for an additional cost.

Medicare Has New Quality Information

If you are thinking about joining a Medicare managed care plan or changing to a new plan, Medicare now has new information about the quality of health plans that can help you. You can compare the results of health care given by the plan. On the following pages, you will see plan quality information on two measures: Mammography (an x-ray to check for breast cancer) and Doctors Who Communicate Well. You can call **1-800-MEDICARE** (1-800-633-4227, or TDD:1-877-486-2048), or look on the Internet at www.medicare.gov to get more information on quality for health plans in your area.

How can I use information about the quality of health plans?

You can use this Medicare quality information and other information available through 1-800-MEDICARE to help choose the plan that is best for you. On the following pages, Medicare is giving you some information that can help you compare how well Medicare plans give health care for two measures, Mammography and Doctors Who Communicate Well.

Exactly what is meant by quality?

Quality is how well the plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person—and getting the best possible results.

How is health care quality measured?

Medicare measures quality in several ways.

- Managed care plans keep track of the health care services they give you and report that care to Medicare. They use information, sometimes called "performance measures," from the Health Plan Employer Data and Information Set (HEDIS). The quality information in this section and on www.medicare.gov is carefully checked before you see it.
- In the Original Medicare Plan, (see page 13 for definition), similar information is available from bills that doctors sent to Medicare.
- Medicare is now getting information from people in Medicare managed care plans about how satisfied they are with their plans. The survey used to collect this information is called the Medicare Satisfaction Survey, or the Medicare Consumer Assessment of Health Plans

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How is health care quality measured? (continued)

Survey (CAHPS). Medicare uses an outside research company to do the survey and Medicare reports the results back to you. A satisfaction survey is planned in the near future for people in the Original Medicare Plan.

What will I see on the following pages?

On the following pages, you can see how different health plans in your State or area scored on health care quality. You will see just two of the many quality measures that Medicare collected. This will show you the kind of information that is available to you.

- For each measure, you will see a page that tells you about the measure, and why it is important.
- Then, you will see graphs with scores for most of the plans in a State. Remember, not all of these plans may be available in your zip code.
- Look for the page with the graph for your State or area. This graph shows the scores for most health plans in your State or area.
- You should find two separate sets of graphs for your State or area; one set for Mammography and the other for Doctors Who Communicate Well.

How can I get more information?

You can call **1-800-MEDICARE** (1-800-633-4227, or TTY:1-877-486-2048), and get more information on other quality measures such as care for diabetics, and overall plan satisfaction. Or, if you choose, you can get this information on the Internet. Go to www.medicare.gov and click on Medicare Compare.

Mammography

In this section, Medicare is giving you health plan quality information on Mammography.

What is this measure?

This measure looks at the percentage of women between the ages of 52 and 69 who got an x-ray to check for breast cancer (called a mammogram) in the past 2 years.

Important Note: Medicare now covers one mammogram every year for female beneficiaries age 40 or older.

Why is this measure important?

A mammogram is an x-ray of the breast that can help find breast cancer early, when the tumor is so small it cannot be felt. When breast cancer is found early, it is more likely to be treated successfully. There is less chance that the cancer will spread to other parts of the body.

What does this tell you about a health plan?

If the percentage of women receiving a mammogram is HIGH (closer to 100%), the health plan is doing a GOOD job of making sure its members are getting mammograms, which can help find cancer early, when it's easier to treat and cure.

Doctors play an important role in making sure that women get regular mammograms. So do the women themselves. Some health plans make a difference by encouraging doctors to refer women for regular mammograms, and by sending reminders about why mammograms are important.

How do I read the graphs?

First, find the page for your State or area.

- The first bar on the graph shows the score for the Original Medicare Plan in your State. The second bar shows the average score for managed care plans in your State. The rest of the bars show how each managed care plan scored on this measure.

- When you compare plans, look for a difference of **10** percentage points or more between plan scores. Small differences between plans usually do not mean a lot.

- Sometimes you will see more than one bar for the same managed care plan in your area. This is because the same plan covers very different geographic areas. Quality measures may be collected for each area. Look for the one that covers the area where you live by finding the name of your managed care plan with your area in parentheses under it.

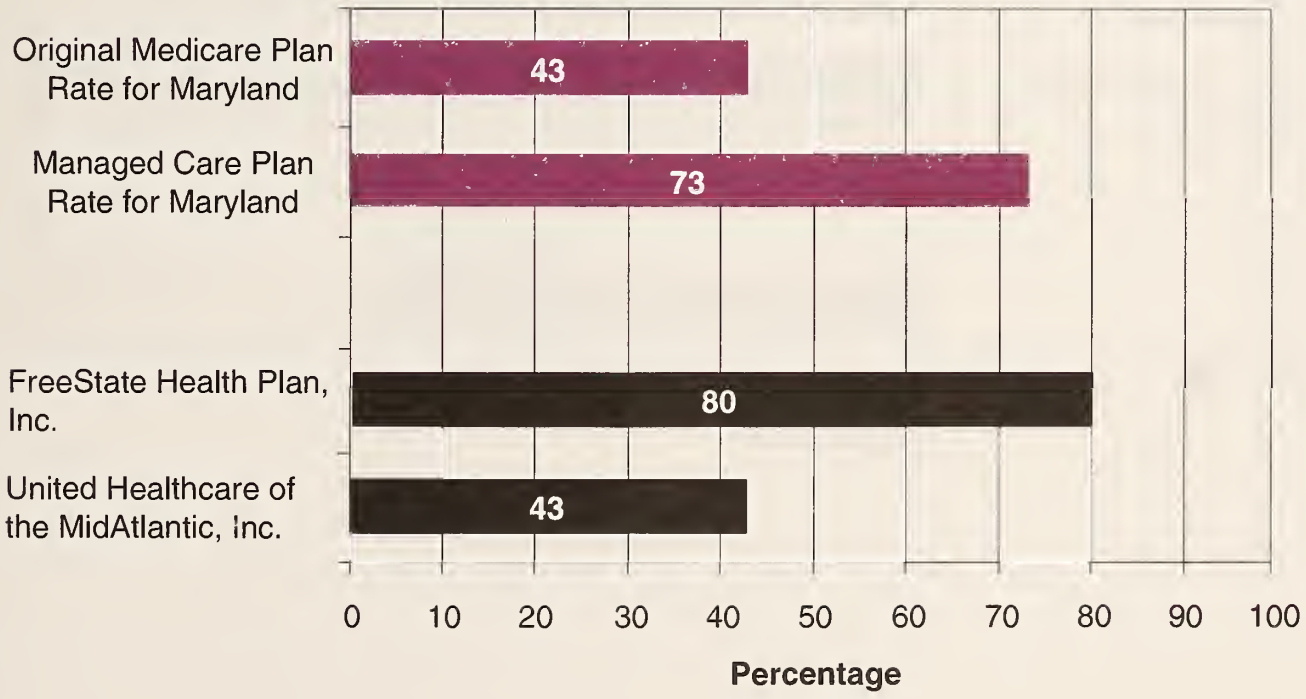
Delaware Health Plans

There were no managed care plans in the Medicare program for this area at the time this information was collected.

Some plans may not be included in the graph below because they were not in the Medicare program at the time this information was collected.

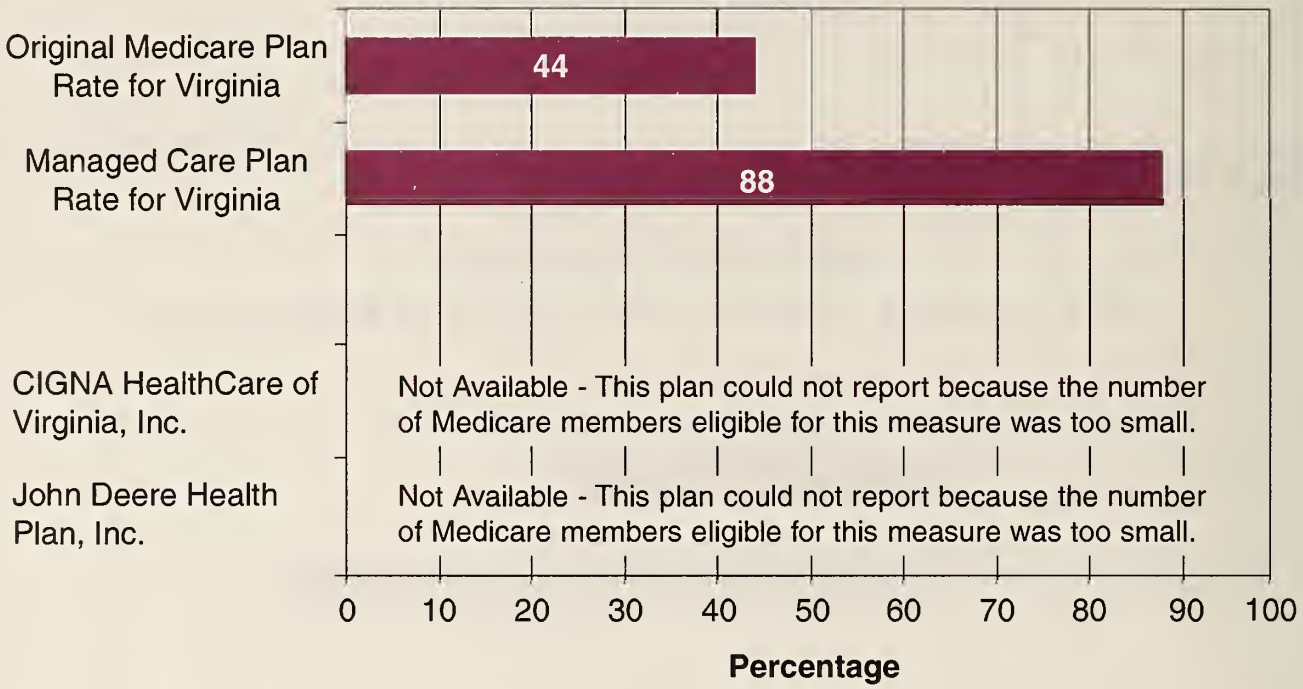
Maryland Health Plans

The Percentage of Women Who Received a Mammogram



Some plans may not be included in the graph below because they were not in the Medicare program at the time this information was collected.

Virginia Health Plans
The Percentage of Women Who Received a Mammogram


Original Medicare Plan Rate for Virginia
44
Managed Care Plan Rate for Virginia
88
CIGNA HealthCare of Virginia, Inc.
Not Available - This plan could not report because the number of Medicare members eligible for this measure was too small.
John Deere Health Plan, Inc.
Not Available - This plan could not report because the number of Medicare members eligible for this measure was too small.
0 10 20 30 40 50 60 70 80 90 100
Percentage

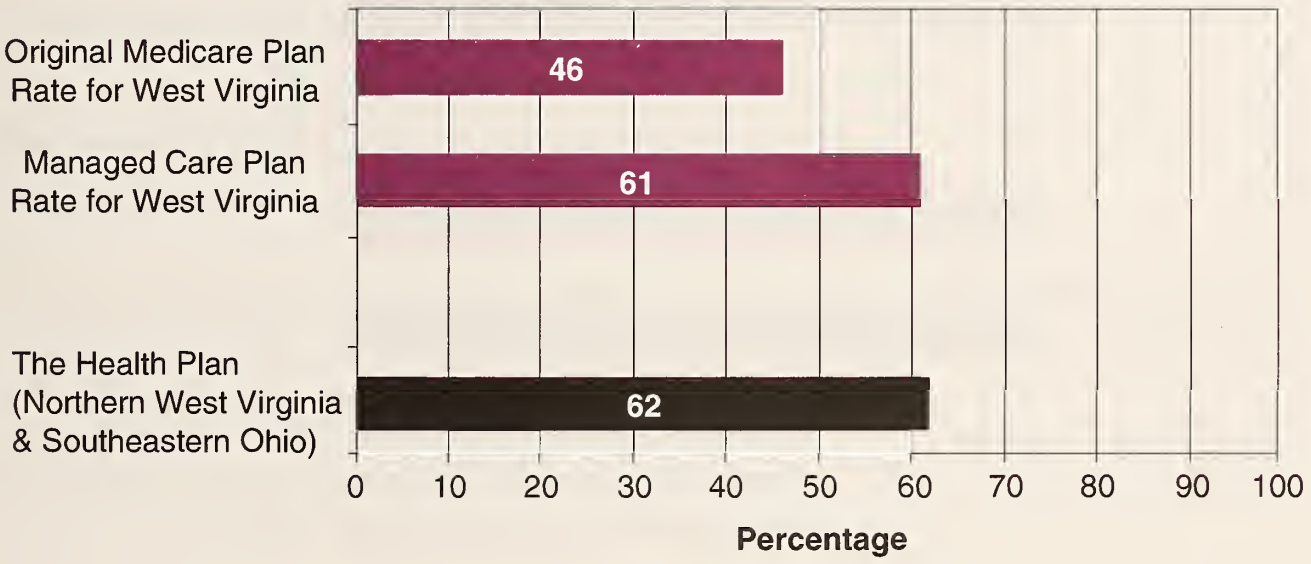
Washington D.C. Health Plans

There were no managed care plans in the Medicare program for this area at the time this information was collected.

Some plans may not be included in the graph below because they were not in the Medicare program at the time this information was collected.

West Virginia Health Plans

The Percentage of Women Who Received a Mammogram



Doctors Who Communicate Well

In this section, Medicare is giving you health plan quality information on Doctors Who Communicate Well.

What is the measure?

A sample of Medicare managed care plan members answered several survey questions that asked them, in the last 6 months, how often their doctors or other health care providers:

- Listened carefully
- Explained things in a way they could understand
- Showed respect for what they had to say
- Spent enough time with them

Graphs for this measure are shown on the following pages.

How do I read the graphs?

First, find the page for your State or area.

- The first bar on the graph shows the average of how plan members generally rated managed care plans in your State. The rest of the bars show how plan members rated each managed care plan on this measure.
- The bars show the percentage of plan members who said their doctors **always** communicate well.
- When you compare plans, look for large differences in the size of the bars. Small differences between plans usually do not mean a lot.
- Sometimes you will see more than one bar for the same managed care plan in your area. This is because the same plan covers very different geographic areas. Quality measures may be collected for each area. Look for the one that covers the area where you live by finding the name of your managed care plan with your area in parentheses under it.

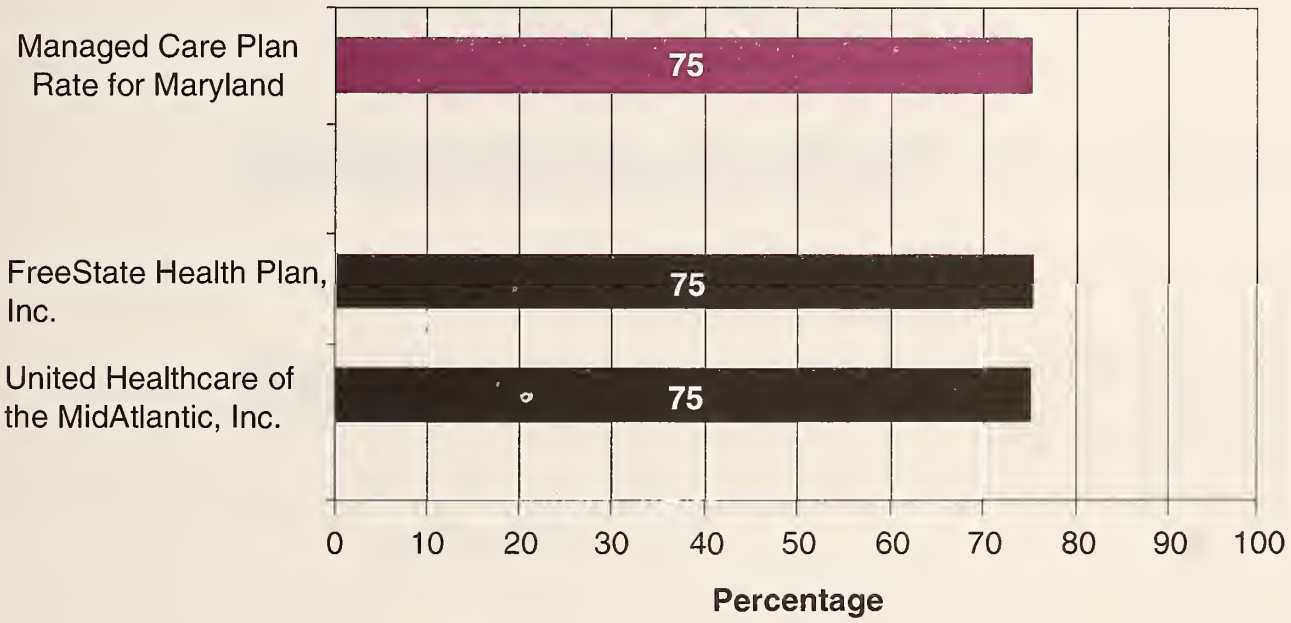
Delaware Managed Care Plans

There were no managed care plans in the Medicare program for this area at the time this information was collected.

Some plans may not be included in the graphs below because they were not in the Medicare program at the time this information was collected.

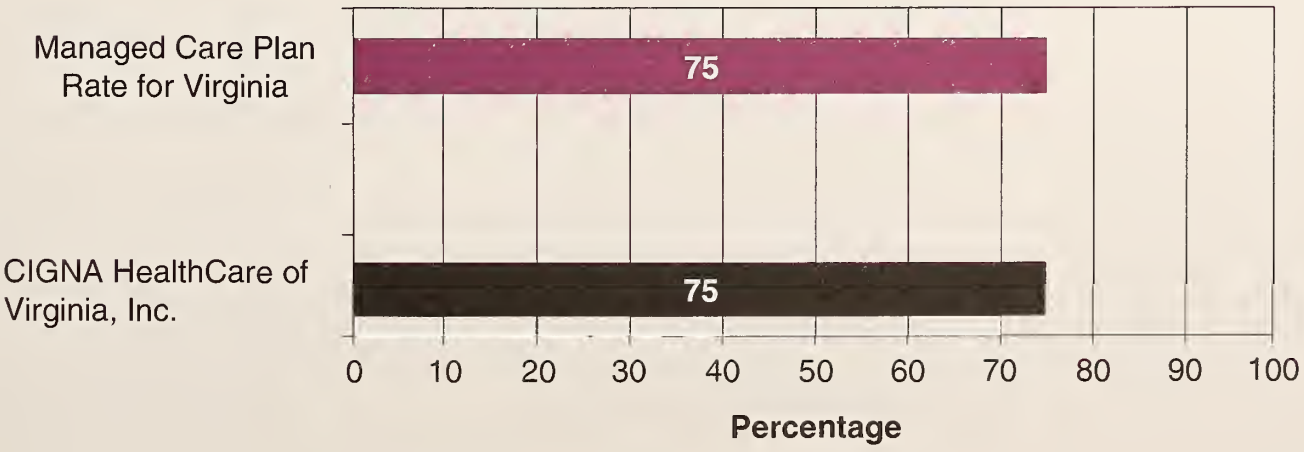
Maryland Managed Care Plans

Doctors Who Communicate Well



Virginia Managed Care Plans

Doctors Who Communicate Well



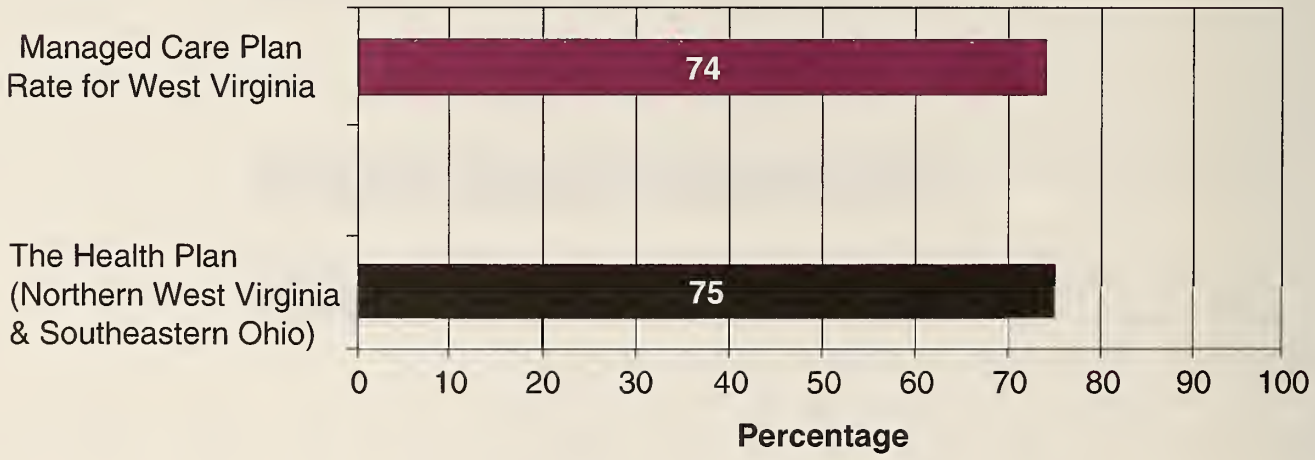
Washington D.C. Managed Care Plans

There were no managed care plans in the Medicare program for this area at the time this information was collected.

Some plans may not be included in the graph below because they were not in the Medicare program at the time this information was collected.

West Virginia Managed Care Plans

Doctors Who Communicate Well



Who to call for help with your Medicare questions

Medicare works with different groups who can help you with your Medicare questions. On the next three pages are the phone numbers you may call for help. If there is a special number for your State, it will be listed. If you are in a Medicare managed care plan, you should call your plan with questions about bills, health services, and appeals. (see Local Information 1-2 in the center section)

IF YOU HAVE QUESTIONS ABOUT...	CALL...	SEE PAGE...
Bills	Carrier or Fiscal Intermediary	23
Changing your address	Social Security Administration	22
Discrimination (to report)	Office for Civil Rights	23
Durable Medical Equipment (like wheelchairs)	Durable Medical Equipment Regional Carrier	22
Fraud and Abuse (reporting)	Office of the Inspector General	22
Health Fairs (local)	Health Care Financing Administration Regional Office	23
Health Plan Options	1-800-MEDICARE Helpline	24
Help with an Appeal	State Health Insurance Assistance Program	24
Home Health Care (Coverage)	Regional Home Health Intermediaries	22
Hospice Care (Coverage)	Regional Home Health Intermediaries	22
Joining Part A or Part B	Social Security Administration	22
Kidney dialysis (quality of care)	End-Stage Renal Disease Network	22
Nursing Homes	Ombudsman	22
Premium Amounts (Medicare)	Social Security Administration	22
Publications (Medicare)	1-800-MEDICARE Helpline	22
Quality of Care	Peer Review Organization	24
Railroad Retirement Benefits	Railroad Retirement Board	22
Social Security benefits	Social Security Administration	22

1-800-MEDICARE Helpline

Call about:

- TTY/TDD and local phone numbers
- General Medicare information
- Ordering Medicare publications
- Information about health plans

All States

1-800-MEDICARE
1-800-633-4227
TTY: 1-877-486-2048

Inspector General

Call about:

- Reporting fraud and abuse

All States

1-800-447-8477
TTY: 1-800-377-4950

Railroad Retirement Board

Call about:

- Lost RRB Medicare card, address change
- Part A bills and services (Fiscal Intermediary)
- Part B bills and services (United HealthCare)

RRB Beneficiaries Only

1-800-808-0772 (RRB)
1-800-833-4455 (UHC)

Social Security Administration

Call about:

- Changing your address
- Medicare Part A or Part B
- Lost Medicare card

All States

1-800-772-1213
TTY: 1-800-325-0778

Durable Medical Equipment Carrier

Call about:

- Bills for durable medical equipment
- List of approved suppliers of this equipment

Delaware	1(800)842-2052
Maryland	1(800)444-4606
Virginia	1(800)270-2313
Washington D.C.	1(800)270-2313
West Virginia	1(800)270-2313

End-Stage Renal Disease

Call about:

- End-Stage Renal Disease (ESRD)
- ESRD quality of care

Delaware	1(800)548-9205
Maryland	1(804)794-3757
Virginia	1(804)794-3757
Washington D.C.	1(804)794-3757
West Virginia	1(804)794-3757

Fiscal Intermediaries

Call about:

- Part A bills and services
- Hospital care services
- Skilled nursing care services
- Fraud and abuse

Delaware	1(800)442-8430
Maryland	1(800)444-4606
Virginia	1(540)985-3931
Washington D.C.	1(402)351-2860
West Virginia	1(540)985-3931

Health Care Financing Administration

Call about:

- Local seminars and health fairs
- Reporting a complaint

Delaware	**All states in this book**
Maryland	
Virginia	1(215)861-4226
Washington D.C.	
West Virginia	

Long-Term Care Ombudsman

Call about:

- Information about nursing homes
- Resolving problems with nursing homes

Delaware	1(800)223-9074
Maryland	1(800)243-3425*
Virginia	1(800)552-3402*
Washington D.C.	1(202)434-2190
West Virginia	1(304)558-3317

Medicare Carriers

Call about:

- Part B bills
- Part B services
- Fraud and abuse

Delaware	1(800)444-4606
Maryland	1(800)444-4606
Virginia**	1(800)444-4606
Virginia†	1(800)552-3423*
Washington D.C.	1(800)444-4606
West Virginia	1(800)848-0106

Office for Civil Rights

Call about:

- Discrimination

Delaware	**All states in this book**
Maryland	
Virginia	1(800)368-1019
Washington D.C.	
West Virginia	

*in-state calls only

**Trailblazers Fairfax and Alexandria Counties, Arlington †United Healthcare/Travelers. Ins.

Peer Review Organizations

Call about:

- Quality of care complaints
- Filing an appeal or complaint

Delaware	1(800)422-8804*
Maryland	1(800)492-5811
Virginia	1(800)545-3814*
Washington D.C.	1(800)999-3362
West Virginia	1(800)422-8804*

Regional Home Health Intermediaries

Call about:

- Home health care
- Hospice care
- Fraud and abuse

Delaware	1(515)246-0126
Maryland	1(800)444-4606
Virginia	1(515)246-0126
Washington D.C.	1(800)444-4606
West Virginia	1(515)246-0126

State Health Insurance Assistance Program

Call about:

- Supplemental Insurance Policies (Medigap)
- Medicare plan choices
- Help with filing an appeal

Delaware	1(800)336-9500*
Maryland	1(800)243-3425*
Virginia	1(800)552-3402
Washington D.C.	1(202)676-3900
West Virginia	1(877)987-4463

State Insurance Departments

Call about:

- Supplemental Insurance Policies (including Medigap)

Delaware	1(800)282-8611*
Maryland	1(800)492-6116
Virginia	1(800)552-7945
Washington D.C.	1(202)727-8000
West Virginia	1(800)642-9004*

State Medical Assistance Office

Call about:

- Low income programs to help pay medical bills

Delaware	1(800)372-2022
Maryland	1(800)463-3461
Virginia	1(804)786-7933
Washington D.C.	1(202)727-0735
West Virginia	1(304)926-1700

*in-state calls only

Your Medicare Patient Rights

If you have Medicare, you have certain guaranteed rights. You have them whether you are in the Original Medicare Plan or a Medicare managed care plan.

- You have the right to get emergency care when and where you need it, without prior approval. If you think your health is in serious danger because you have severe pain, a bad injury, sudden illness, or an illness quickly getting much worse, you can get emergency care anywhere in the United States.
- You have the right to appeal if Medicare does not pay for a covered service you have been given, or if your doctor or hospital does not give you a service that you believe should be covered (see pages 26-27).
- You have the right to know all your treatment options from your health care provider in language that is clear to you. Medicare must give you information about what is covered and how much you have to pay. Medicare managed care plans cannot have rules that stop a doctor from telling you everything you need to know about your health care, including treatment options.
- You have the right to have any personal information that Medicare collects kept private. Medicare may collect information about you as part of its regular business, such as paying your bills. The law requires Medicare to keep this information private. When Medicare asks for this kind of information, we must tell you that the law lets us collect it for payment and health treatment purposes. You have the right to know why we need it, whether it is required or optional, what happens if you don't give the information, and how it will be used. If you want this information call 1-800-MEDICARE (1-800-633-4227) and ask for more information about how Medicare uses personal information.

If You Are in a Medicare Managed Care Plan ▸

- You have a right to choose a women's health specialist from your plan's list of doctors to meet your women's health care needs.
- If you have a complex or serious medical condition, you have a right to have enough visits to a specialist to deal with your needs.

If You Are in a Medicare Managed Care Plan (continued) ▸

- You have a right to know how your plan pays its doctors. If you want to know how your plan pays its doctors, the plan must tell you in writing. You also have the right to know whether your doctor owns all or part of a health care facility. For example, a lab that he or she refers you to for a blood test.
- If you have concerns or problems with your plan which are not about payment or service requests, you have a right to file a grievance. A grievance is a type of complaint. For example, if you believe your plan's hours of operation should be different, you can file a grievance. If you believe you are not getting a high quality of care, you may either file a grievance with your plan or with the Peer Review Organization (PRO) in your State (see page 24).

Your Medicare Appeal Rights

You have the right to appeal any decision about your Medicare services. This is true whether you are in the Original Medicare Plan or a Medicare managed care plan. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can appeal.

Appeal Rights Under The Original Medicare Plan ▸

If you are in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why your bill was not paid and what appeal steps you can take.

Appeal Rights Under Medicare Managed Care Plans ▸

If you are in a Medicare managed care plan, you can file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must answer you within 72 hours.

Appeal Rights Under Medicare Managed Care Plans (continued) ▸

The Medicare managed care plan must tell you in writing how to appeal. After you file an appeal, the plan will review its decision. Then, if your plan does not decide in your favor, the appeal is reviewed by an independent organization that works for Medicare, not for the plan. See your plan's membership materials or contact your plan for details about your Medicare appeal rights.

Your Medicare Protections

You are Protected from Unexpected Bills ▸

An Advance Beneficiary Notice is a written notice that tells you why Medicare probably (or certainly) will not pay for a service. A doctor or supplier might give you this notice before you are given the service. If you still want to get the service, you will be asked to sign an agreement that you will pay for the service yourself if Medicare does not pay for it. Advance Beneficiary Notices are used in the Original Medicare Plan, but not in Medicare managed care plans.

You are Protected From Discrimination ▸

Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your race, color, sex, national origin, disability, or age. If you think that you have not been treated fairly for any of these reasons, call the Office for Civil Rights in your State (see page 23).

You are Protected When You Are in the Hospital ▸

If you are admitted to a Medicare participating hospital, you should be given a copy of *An Important Message From Medicare*. It explains your rights as a hospital patient. If you are not given one, ask for it.

The Message tells you:

- You have the right to get all of the hospital care that you need, and any follow-up care after you leave the hospital.
- What to do if you think the hospital is making you leave too soon.

If you have questions about this, call the Peer Review Organization (PRO). Their number is on the message. You may be able to stay in the hospital at no charge while they review your case. The hospital cannot force you to leave before the PRO makes a decision.

You are Protected in a Skilled Nursing Facility ▸

A skilled nursing facility (SNF) is a qualified facility that has the staff and equipment to provide skilled nursing care or skilled rehabilitation services and other related health services. Some nursing homes provide this type of skilled care. There are quality standards that every SNF must meet to protect you, including:

- The SNF cannot make you pay anything to be admitted unless it is clear to you that Medicare does not cover the cost of services;
- You must be told right away if the SNF decides you do not need the level of skilled care covered by Medicare. If you disagree with this decision, you may ask that the SNF submit something called a "demand bill" to Medicare.

  The SNF must submit the demand bill and cannot make you pay a deposit for services that Medicare may not cover until Medicare gives its decision.

  You must pay for any coinsurance while the demand bill is being processed, and for services not covered by Medicare.

If you have questions about SNF care, contact your Fiscal Intermediary (see page 23).

You are Protected When Your Home Health Care Ends ▸

Home health agencies must give you a notice that explains why and when they think Medicare will stop paying for your home health care. If you think you still need home health care and you think Medicare should keep paying, you can ask Medicare for an official decision.

To get an official decision, you should:

- Keep getting home health care if you think you need it. Ask how much it will cost. You should talk to your doctor and family about this.
- Pay the home health agency for these services.
- Ask the home health agency to send your claim to Medicare so that Medicare will decide if it will pay.

If Medicare decides to pay, you will get back all of your payments, except for any coinsurance for durable medical

You are Protected When Your Home Health Care Ends (continued) ▸

equipment. If Medicare decides not to pay, you will get a letter that tells you how to appeal. You can always get home health care if you want to pay for it yourself. If you have questions about home health care under the Original Medicare Plan, call your Regional Home Health Intermediary (see page 24). If you have questions about home health care in a Medicare managed care plan, call your plan.

Your Medigap Policy Protections

You may have the right to buy a Medigap policy, even if you are in poor health. See page 14 for more information about these rights.

You Can Help Protect Yourself and Medicare From Fraud and Abuse

Most doctors and other kinds of health care providers who work with Medicare are honest and want to provide health care to you. There are a few who are not honest. We are working very hard with other government agencies to protect the program from the few who try to cheat Medicare.

With help from you, health care providers, and law enforcement, Medicare is solving this problem. Medicare has sent some dishonest providers to jail, and some have left the Medicare program. These actions have saved money for taxpayers.

What You Can do to Help Fight Fraud and Abuse ▸

Every time you get health care in the Original Medicare Plan, you get an Explanation of Medicare Benefits or a Medicare Summary Notice from a company that handles bills for Medicare. It shows what services or supplies were charged and how much Medicare paid. Check it for mistakes. Make sure that Medicare wasn't charged for any services or supplies that you did not get. If you see a charge on your bill that may be wrong, call the health care provider and ask about it. If you think that a provider may be cheating or abusing Medicare, call the Medicare Carrier or Fiscal Intermediary. Their phone number is printed on the top of the notice.

What You Can do to Help Fight Fraud and Abuse (continued) ▸

You can also call the Inspector General's hotline to report Medicare fraud. The hotline number is 1-800-HHS-TIPS (1-800-447-8477). Medicare will not use your name if you ask that it not be used.

Fighting fraud and abuse can pay. You may get a reward of up to $1,000 if:

- You report Medicare fraud and abuse,

AND

- Your report leads directly to the recovery of at least $100 of Medicare money,

AND

- The fraud and abuse you report is not already being investigated.

If you want to know more about this program, call your Medicare Carrier or Fiscal Intermediary (see page 23).

Whether you are in the Original Medicare Plan, or a Medicare managed care plan, you may want to know:

Q1: What if I'm over 65 and didn't sign up for Part B when I first became eligible?

If you did not take Part B when you were first eligible for Medicare, you may still be able to sign up during a General Enrollment Period.

This happens from January 1 through March 31 of each year. You can sign up for Part A or Part B at your local Social Security office. Your Part B coverage will start on July 1 of that year. Remember, the cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not take it, except in special cases (see below).

Q2: How do I sign up for Part B if I or my spouse continued working after age 65?

Many people retire and start their Medicare Part B coverage when they turn 65. However, you or your spouse might continue working. If so, you may wish to keep any employer or union group health plan coverage that you have through that employment. You don't have to sign up and pay for Part B if you have this other coverage. You will have a Special Enrollment Period that gives you another chance to sign up for Part B later, when you need it.

You can sign up:

1. Anytime you are still covered by the employer or union group health plan, or
2. Within 8 months of the date when your employer or union group plan coverage ends, or when the employment ends (whichever is first).

If you are disabled and working (or you have coverage from a working family member), the Special Enrollment Period rules also apply.

Most people who sign up for Part B during a Special Enrollment Period do not pay higher premiums.

For more information about Part B, call your local Social Security office, or call Social Security at 1-800-772-1213 to sign up for Part B. Railroad Retirees should call the Railroad Retirement Board (see page 22).

Q3: How does travel affect my health care?

A: The Original Medicare Plan generally does not cover care outside the United States, but some Medicare managed care plans and Medigap policies do. If you are a Railroad Retiree, contact the Railroad Retirement Board (RRB) or RRB Carrier for information on their rules about care in another country (see page 22).

Medicare managed care plans require you to live and get your care in the service area of the plan. If you travel a lot or live in another State for part of the year, you should call your plan and ask if they cover services when you are out of the service area temporarily.

Q4: Does Medicare pay for outpatient prescription drugs?

A: The Original Medicare Plan does not cover outpatient prescription drugs except in a few cases, like certain cancer drugs. However, many Medicare managed care plans cover outpatient prescription drugs, up to certain limits. Some Medigap policies also cover certain outpatient prescription drugs.

Q5: If I have Medicare and Medicaid, who should pay my health care bills first?

A: Your bill should always be sent to Medicare first. The part of the bill that Medicare does not pay will then be sent to your State Medicaid program for further payment.

Q6: What does Medicare Secondary Payer mean?

A: Medicare Secondary Payer means that other insurance pays your health care bills first and Medicare pays second. Other insurance that may have to pay first includes: employer group health plan insurance, automobile or non-automobile no-fault insurance, any liability insurance, black lung benefits, and workers' compensation. It is important that you tell your doctor or hospital that you have other insurance. If you have questions about who pays first, call your Medicare Carrier (see page 23).

Q7: What is a "Private Contract," and how does it work?

A: A Private Contract is an agreement between you and a doctor who has decided not to give services through the Medicare program.

Under a private contract:

- Medicare will not pay the doctor or you for the services you get.
- You will have to pay whatever the doctor charges you (there are no limits on the charge).
- Medicare managed care plans will not pay for these services.
- No claim should be submitted. Medicare will not pay if a claim is submitted.
- If you have a Medigap policy, it will not pay anything for services under a private contract. Contact your Medigap insurance company before you get the service.
- Many other insurance plans will not pay for the service either.

The private contract only applies to the services you get from the doctor who asked you to sign it. You cannot be asked to sign a private contract when you are facing an emergency or urgent health situation. You may want to talk with someone in your State Health Insurance Assistance Program before signing a private contract (see page 24). You can also call 1-800-MEDICARE (1-800-633-4227) and ask for information on private contracts.

You may choose to pay on your own for services that the Original Medicare Plan does not cover. In this case, your doctor does not have to stop providing services through Medicare or ask you to sign a private contract. You are always free to get non-covered services on your own if you choose to pay for these services yourself.

Q8: What is the year 2000, or "Y2K" computer problem?

A: Most computer software programs use dates with only the last two numbers of the year. Because of this, the year 2000 will show up as 00. The computer will see it as 1900. This could cause problems with many computer systems. To prevent these problems, the government, doctors, hospitals and others who use computers are fixing their computers so they will run smoothly into the year 2000.

Q9: Are Medicare's computers ready for the year 2000?

A: Yes. Medicare's computers are ready for the year 2000. We are also working with health care providers, suppliers, and the companies that handle Medicare bills and payments to be sure that their computers will be ready. You will not have to pay any bills that Medicare would ordinarily pay because of a computer problem. If you need general information or have problems getting a bill paid that you think is related to this computer problem, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

If you are in the Original Medicare Plan, you may want to know:

Q10: How are my bills paid in the Original Medicare Plan?

A: When you get services covered by the Original Medicare Plan, your provider sends the bill to a private company (the Fiscal Intermediary for Part A services or the Medicare Carrier for Part B services) that handles bills for Medicare. After they process the bill, you will get an Explanation of Medicare Benefits or a Medicare Summary Notice. Please check the notice to be sure Medicare was not billed for services, medical supplies, or equipment that you did not get. If you have any questions about bills or services listed on the notice, call the health care provider and ask about it. If you disagree with what is covered or paid, you have the right to file an appeal (see page 26). If you think the provider is being dishonest, read the fraud and abuse section on page 29.

Q11: How can I tell if Medicare was billed for the services that I received?

A: Write to the health care provider and ask for an itemized statement. This statement will list each Medicare item or service you have received from your doctor, hospital, or any other health supplier.

Q12: What is "assignment" in the Original Medicare Plan?

A: In the Original Medicare Plan, doctors and other providers who accept assignment accept the amount Medicare approves (the approved amount) for a certain service or supply as payment in full. (You are still responsible for any coinsurance amount.) Always ask your doctors and medical suppliers whether they accept assignment because:

- It could save you money!
- Doctors who do not accept assignment can make you pay the full amount they are allowed to charge at the time of service. Medicare will reimburse you later for its share of the bill.
- Doctors and other health care providers who do not accept assignment may charge up to 15% over Medicare's approved payment amount (the limiting charge). The limiting charge does not always apply.

For more details about assignment, call 1-800-MEDICARE (1-800-633-4227) and ask for a copy of *Does Your Doctor or Supplier Accept Assignment*?

If you are thinking about joining a Medicare managed care plan, you may want to know:

Q13: Why do some Medicare managed care plans leave Medicare?

A: Each year, managed care plans have to choose whether to continue doing business with the Medicare program, and whether to raise or lower premiums and benefits. Some managed care plans make business decisions to leave Medicare in certain areas. Your plan must let you know if it intends to leave Medicare at the end of the year. The notice the plan must send you will tell you if other Medicare managed care plans are offered in your area, and what protections you have.

If the plan's quality is poor or they commit fraud, they can be asked to leave Medicare. You will get a notice before this happens. The notice will tell you how to find a new plan, and what protections you have.

Q14: What can I do if my Medicare managed care plan does not stay with Medicare?

A: If there are other Medicare managed care plans in your area, you may join one. Or, you can return to the Original Medicare Plan. You should learn as much as you can about your options before making a decision. No matter what you choose, you are still in the Medicare program and will get all Medicare covered services. You can read about your Medigap protections on page 14.

Q15: What are primary care doctors?

A: A primary care doctor is usually a family doctor or internist who gives regular, basic health care. In managed care plans, you either choose or are assigned a primary care doctor who belongs to the plan. He or she arranges your health care with you and gives you the OK (see question 16 on page 37) to see specialists who belong to the plan when you need one.

If you already have a doctor or specialist you like, ask if he or she is in the plan and would continue to see you if you join the plan.

Q16: What is a referral?

A: In a Medicare managed care plan, a referral is your primary care doctor's OK for you to see a certain specialist or get certain services. Most Medicare managed care plans require referrals.

Important: You may have to pay the entire bill if:

(1) you see a different doctor from the one on the referral, or

(2) you do not have a referral, or

(3) the service is not for an emergency or urgently needed care (question 17).

Q17: What is a medical emergency? How do I get emergency care?

A: A medical emergency is when you believe that your health is in serious danger - when every second counts. You may have severe pain, a bad injury, sudden illness, or an illness quickly getting much worse. All Medicare managed care plans must allow you to get emergency care whenever you need it from any provider in the United States. You do not need permission from your primary care doctor first. Your plan must pay for the emergency care. If you get a bill, give it to the plan to pay. If your plan does not pay for your emergency service, you have the right to appeal (see page 26).

Q18: What is "urgently needed care"? How do I get urgently needed care?

A: When you need care for a sudden illness or injury, but it is not a medical emergency, it is called urgently needed care. You get urgently needed care from your primary care doctor. However, if you are out of the Medicare health plan's service area for a short time and cannot wait until you return home, your plan must pay for urgently needed care. If it does not, you have the right to appeal.

If you need special health care, you may want to know:

Q19: How can I get information about home health, hospice, or mental health care, or care in a skilled nursing facility?

A: Medicare pays for a variety of services if you need care at home, hospice care (for terminally ill patients), mental health care, or care in a skilled nursing facility. You must meet certain conditions to qualify for these types of services.

Questions about:

Home Health or **Hospice Care** - Call your Regional Home Health Intermediary (see page 24), or order pamphlets on these topics from 1-800-MEDICARE (1-800-633-4227).

Mental Health Care - Call 1-800-MEDICARE (1-800-633-4227) for more information.

Skilled Nursing Facility Care - Call your Fiscal Intermediary (see page 23), or order a copy of *The Guide to Choosing a Nursing Home* from 1-800-MEDICARE (1-800-633-4227).

You can also find these pamphlets on the Internet at www.medicare.gov.

Q20: What is long-term care?

A: Long-term care is care that helps you with your daily needs, such as bathing, dressing, toileting, and eating. This care can be provided safely and easily by people without professional skills or training. You can get long-term care at home or in a nursing home if you are disabled or have a long-term illness. See question 21 for payment information.

Q21: Who pays for long-term care?

Generally, Medicare does not pay for long-term care. If your income and assets are limited, your State may be able to help you pay for long-term care. If you qualify for both Medicare and Medicaid, most health care costs are covered. You may also qualify for the Medicaid nursing home benefit. Call your state medical assistance office for more information (see page 24).

You can buy long-term care insurance from a private insurance company, but be sure that the agent is licensed in your State. Each policy may be different. Contact your State Health Insurance Assistance Program for more information (see page 24) or write to National Association of Insurance Commissioners, Publications Dept., 120 West 12th Street, Suite 1100, Kansas City, MO 64105. Ask for a copy of *The Shopper's Guide to Long-Term Care Insurance*. You may also call 1-800-MEDICARE (1-800-633-4227) to get a copy of the *Guide to Health Insurance for People with Medicare*.

Q22: How can I find out about the nursing homes in my area?

A: You can now get important information about the nursing homes in your area on the Internet at www.medicare.gov. Click on "Nursing Home Compare" to see where they are located in your area, how big they are, and if there have been problems. If you don't have a computer, your local library or senior center may be able to help you look at this information.

Free Medicare and Related Publications

To ask for a copy of...

- *Does Your Doctor or Supplier Accept Assignment?*
- *Guide to Choosing a Nursing Home*
- *Guide to Health Insurance for People With Medicare*
- *Health Plan Comparison Information*
- *Learning About Medicare Health Plans*
- *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*
- *Medicare Health Plan Quality and Satisfaction Information*
- *Medicare Home Health Care Services*
- *Medicare Hospice Benefits*
- *Medicare Preventive Services*
- *Medicare Supplemental Insurance (Medigap) Policies and Protections*
- *Medicare & You (Available in English, Spanish, Audio-tape, or Braille)*
- *Worksheet for Comparing Medicare Health Plans*
- *Your Guide to Medicare Medical Savings Accounts*
- *Your Guide to Private Fee-for-Service Plans*

Call: 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

To request a copy of...

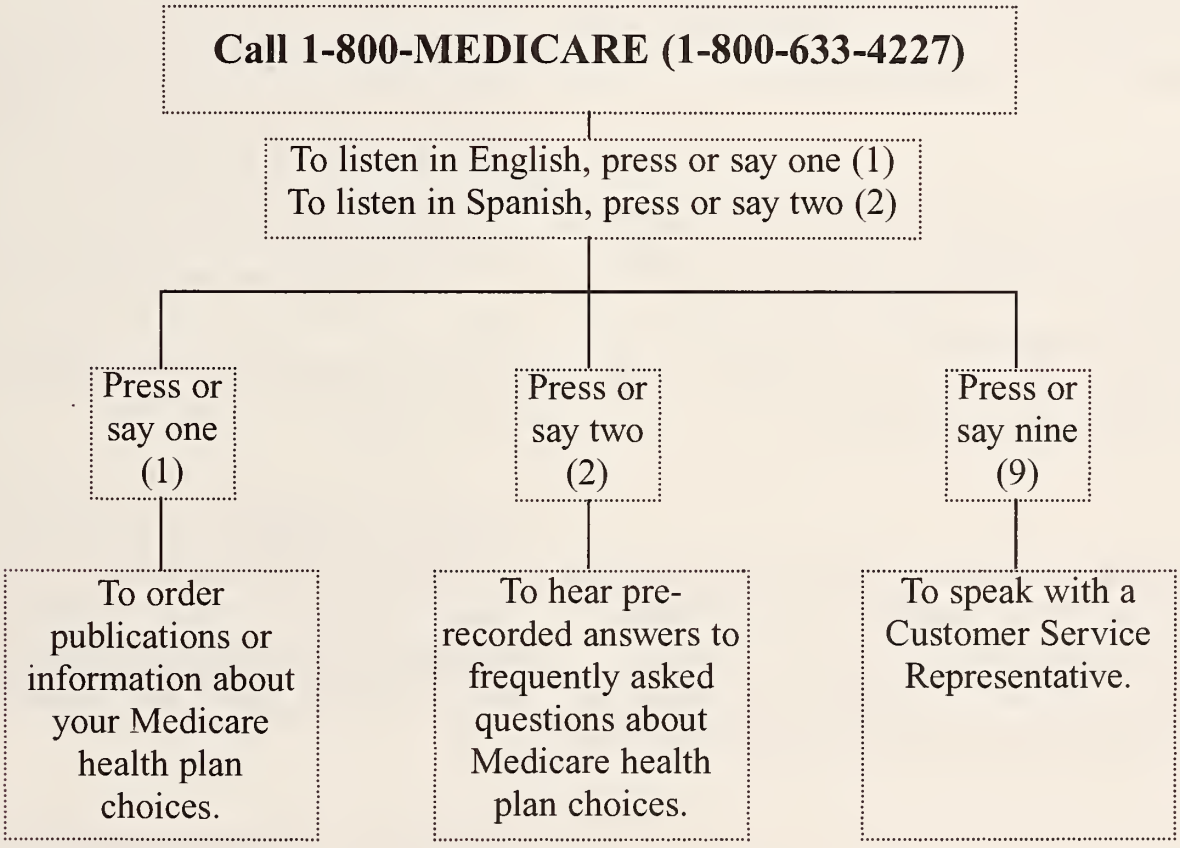
- *A Shopper's Guide to Long-term Care Insurance*

Write to:

NAIC
Publications Dept.,
120 West 12th Street
Suite 1100
Kansas City, MO 64105

Call 1-800-MEDICARE to:

- Get more help with your questions about Medicare.
- Order Medicare publications. (Some are available in Spanish, audio-tape, and braille.)
- Order detailed information about the Medicare managed care plans in your area.
- Order Medicare health plan quality and customer satisfaction information.
- Listen to recorded questions and answers on topics such as Medicare health plan choices, and health plan quality information.


Call 1-800-MEDICARE (1-800-633-4227)
To listen in English, press or say one (1)
To listen in Spanish, press or say two (2)
Press or say one (1)
Press or say two (2)
Press or say nine (9)
To order publications or information about your Medicare health plan choices.
To hear pre-recorded answers to frequently asked questions about Medicare health plan choices.
To speak with a Customer Service Representative.

Important Facts About 1-800-MEDICARE

- If you are hearing or speech impaired, call our TTY/ TDD line toll-free at 1-877-486-2048 for these options.
- If you have a touch-tone phone, press the numbers listed. If you have a rotary phone, or if it is hard to dial, after you have dialed 1-800-633-4227 you can just say the numbers to request what you want.
- You can hear a recording with answers to frequently asked questions, and can order publications 24 hours a day, 7 days a week.
- You can talk with a Customer Service Representative between 8:00 a.m. and 4:30 p.m. in your time zone, Monday through Friday.

Benefit Period - The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Coinsurance - The percent of the Medicare approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the cost of the service (like 20%).

Copayment - In some Medicare health plans, the amount that you pay for each medical service you get, like a doctor visit. In the Medicare program, a copayment is usually a fixed amount you pay for a service, like $5 or $10.

Deductible - The amount you must pay for health care, before Medicare begins to pay. There is a deductible for each benefit period for Part A, and each year for Part B. These amounts can change every year.

Medicaid - A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from State to State, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary - Services or supplies that:

- are proper and needed for the diagnosis, or treatment of your medical condition;
- are provided for the diagnosis, direct care, and treatment of your medical condition;
- meet the standards of good medical practice in the medical community of your local area; and
- are not mainly for the convenience of you or your doctor.

Medicare + Choice - A new Medicare program that allows for more choices among Medicare health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease.

Peer Review Organization (PRO) - Groups of practicing doctors and other health care experts paid by the Federal Government to monitor and improve the care given to Medicare patients. They must review your complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers.

Premium -Your monthly payment for health care coverage to Medicare, an insurance company, or a health care plan.

Reserve Days - Sixty days that Medicare will pay for when you are put in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($384 in 1999).

Skilled Care - A level of care that must be given or managed by licensed health care professionals and is under the general direction of a doctor. All of your needs are taken care of with this type of service, including giving direct services. As long as you need skilled care, it makes no difference whether your illness is acute, chronic, or terminal. Any service that could be safely performed by an average nonmedical person (or one's self), without the direct supervision of a licensed health care professional, is not covered.

State Health Insurance Assistance Program (SHIP) - A State organization that receives money from the Federal Government to give free health insurance counseling and assistance to people with Medicare.

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